Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

PRTF Demonstration Grant
Describe any significant changes to the approved waiver that are being made in this renewal application:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Psychiatric Residential Treatment Facilities Application

C. **Type of Request: renewal [PRTF Demonstration Grant]**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number:

Revision Level:

Effective Date: *(mm/dd/yy)*

Waiver Number: MD.01.01.00
Draft ID: MD.01.01.00

Renewal Number: 01

D. **Type of Waiver** *(select only one):*
Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/08

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

☑ **[Demonstration Only] Psychiatric Residential Treatment Facility (PRTF)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the PRTF level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of the waiver is to implement a "wraparound" model of community-based service delivery for (1) children under 18 years of age with serious emotional disturbance (SED) and (2) youth aged 18 to 21 years with serious mental illness (SMI). The goal is to divert and transition children (under 18 years of age) and youth (aged 18 to 21 years) from psychiatric residential treatment facilities (PRTFs) to the community. This waiver will enable Maryland to serve children and youth in the community who otherwise would only be eligible for Medicaid-funded services in a PRTF. Most children and youth will live with their families in the community. Some children and youth may live in family foster care or a group home placement while they are in the waiver. Reimbursement for foster care and group home placements are not part of the waiver. Participation in this waiver is voluntary.

A fee-for-service (FFS) model will be utilized to provide waiver participants with certain waiver services and specialty mental health services through MHA's specialty mental health system. All waiver participants will be enrolled in Maryland's managed care program, known as HealthChoice, through which all somatic care will be provided.

The program will build up to 400 slots in five years. The program will initially operate in up to four jurisdictions, and may be phased in statewide.

The Mental Hygiene Administration (MHA) within the Department of Health and Mental Hygiene (DHMH) will be the operating agency for this waiver. The Medicaid Division of Waiver Programs (DWP), the single State agency for Medicaid within DHMH, is responsible for oversight of the waiver and ensuring compliance with federal and State laws and regulations relating to operation of the waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. Appendix H contains the Quality Management Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ○ **No**
- ◉ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☑ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

At the onset of the waiver, services will be provided in Baltimore City, Montgomery County, Wicomico County, and St. Mary's County. In subsequent years, services may be provided in additional counties.

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Maryland Department of Health and Mental Hygiene obtained public input in the development of the PRTF Waiver in a number of ways:

• Through a Real Choices grant, DHMH gained input on the initial work on the development of the model from state

and local agencies, provider groups, and consumer advocacy organizations.

• The Real Choices Consumer Advisory Committee has been reconvened as the Maryland 1915(c) Waiver Advisory Group. This group includes representatives from state and local agencies, provider groups, and advocacy groups. The 1915(c) Waiver Advisory Group meets regularly to inform the development of the waiver and get a progress report on the status of the waiver. The Group members give feedback and direction on the various aspects of the waiver application, implementation, and operational processes.

• In addition, when new or amended regulations or waiver amendments/renewals are proposed by DHMH, a notice is required to be published in the Maryland Register. Regulations may not be promulgated until an opportunity for public comment is provided, including a response from DHMH to all public comments received.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Wessely
First Name:	Jane
Title:	Chief, Division of Waiver Programs, Office of Health Services
Agency:	Maryland Department of Health and Mental Hygiene
Address:	201 W. Preston Street, Room 121
Address 2:	
City	Baltimore
State:	**Maryland**
Zip:	21201
Phone:	(410) 767-5220 **ext.**
Fax:	(410) 333-5212
E-mail:	wesselyj@dhmh.state.md.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Zachik
First Name:	Albert
Title:	Director of Child and Adolescent Services
Agency:	Mental Hygiene Administration, Department of Health and Mental Hygiene
Address:	55 Wade Ave.

Address 2:	Mitchell Building, Spring Grove Hospital Center
City	Catonsville
State:	**Maryland**
Zip:	21228
Phone:	(410) 402-8487 **ext.**
Fax:	(410) 402-8306
E-mail:	azachik@dhmh.state.md.us

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Alycia Steinberg
	State Medicaid Director or Designee
Submission Date:	Dec 19, 2007

Last Name:	Folkemer
First Name:	John
Title:	Deputy Secretary for Health Care Financing
Agency:	Maryland Department of Health and Mental Hygiene
Address:	201 W. Preston Street, Room 535
Address 2:	
City:	Baltimore
State:	**Maryland**
Zip:	21201
Phone:	(410) 767-4073
Fax:	(410) 333-7687
E-mail:	folkemerj@dhmh.state.md.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Under Section 6063 of the Deficit Reduction Act, Maryland will be able to continue serving children and youth who were

enrolled into the waiver under the authority of the demonstration, until those children and youth graduate from the program after two years or disenroll from the program for any other reason. Maryland will not enroll any new children after the demonstration period ends unless there is a change in federal law which allows the demonstration waiver to become a 1915 (c) waiver. If federal law does change, Maryland plans on converting the demonstration waiver to a 1915(c) waiver.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one: do not complete Item A-2)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the unit name:

   Do not complete item A-2.

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the unit name:
   Mental Hygiene Administration, DHMH

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

Appendix A: Waiver Administration and Operation

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   DHMH is the single state Medicaid agency authorized to administer Maryland's Medical Assistance Program. DHMH's Office of Health Services (OHS) oversees this waiver through its Division of Waiver Programs (DWP). In this capacity, OHS oversees the performance of MHA, operating state agency for the waiver.

   OHS is responsible for monitoring MHA through: 1) Memorandum of Agreement regarding each administration's roles and responsibilities; 2) Quality Management Plan that outlines in detail, quality assurance activities and each entity responsible for that activity; 3) quarterly reports from MHA on reportable events that include trending and tracking of data and plans for remediation; 4) quarterly inter-agency waiver coordination meetings between DWP and MHA to discuss issues, policy, and remediation planning at least on a quarterly basis.

   As previously stated, OHS and MHA will develop and implement a Quality Management Plan, which is based upon assuring waiver participant health and safety through appropriate level of care determinations, monitoring and

approving plans of care, enrolling qualified providers, monitoring provider performance and providing training, implementing a system for reporting critical events and complaints, and providing administrative oversight and financial accountability.

The DWP will assign a waiver coordinator to this waiver, to conduct an annual review a sample of waiver participants' records, which includes a review of that participant's plan of care and issues a report of findings to MHA. If corrective actions are needed, MHA will develop a plan to systematically address each issue.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   Contracted Project Director

   The Project Director will be responsible for overseeing the implementation of the waiver in the 4 jurisdictions. The Director's responsibilities will include, but not be limited to, providing technical assistance, quality assurance, data collection and analysis, program evaluation, financial oversight, and waiver management. The Program Director will be responsible to MHA and meet all reporting requirements.

   MAPS-MD
   MAPS-MD, the administrative services organization, is contracted by MHA to manage the public mental health system. MAPS-MD determines medical eligibility, pays providers through MMIS, and manages the complaint and appeal process for MHA.

   MHA will serve as the signatory for all contracted entities.

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ○ **Not applicable**

   ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   Core Service Agencies (CSAs) are local public or not-for-profit mental health agencies. CSAs are involved with determining medical eligibility for the waiver by participating in the independent team review convened by MAPS-MD. Medical, psychiatric, and psychosocial evaluations for medical eligibility are performed by licensed psychologists and physicians and are forwarded to MAPS-MD. MAPS-MD convenes the independent team for the review of the medical, psychiatric, and psychosocial evaluations. The independent team convened by MAPS-MD includes a social worker or similar mental health professional at the local CSA, as well as a MAPS-MD care coordinator, and a MAPS-MD physician. CSAs also disseminate information about the waiver to potential enrollees and

assist individuals with waiver enrollment.

☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Core Service Agencies (CSAs) are local public or not-for-profit mental health agencies. CSAs are involved with determining medical eligibility for the waiver by participating in the independent team review convened by MAPS-MD. Medical, psychiatric, and psychosocial evaluations for medical eligibility are performed by licensed psychologists and physicians and are forwarded to MAPS-MD. MAPS-MD convenes the independent team for the review of the medical, psychiatric, and psychosocial evaluations. The independent team convened by MAPS-MD includes a social worker or similar mental health professional at the local CSA, as well as a MAPS-MD care coordinator, and a MAPS-MD physician. CSAs also disseminate information about the waiver to potential enrollees and assist individuals with waiver enrollment.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
MHA will be responsible for the performance of the contracted project director, MAPS-MD, and CSAs.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
MAPS-MD
MAPS-MD, the administrative services organization, is contracted by MHA to manage the public mental health system. MAPS-MD determines level of care (LOC). MHA's Deputy Director of Community Programs and Managed Care is the assigned contract monitor for MAPS-MD. Representatives of MHA leadership, MAPS-MD, and the Director of Community Programs and Managed Care meet bi-monthly to review contract compliance. Additionally, through quarterly meetings with MHA and the Office of Health Services, areas of concern are addressed and MHA follow up with the ASO's contract monitor. MHA communicates the results and any remedial action to OHS.

University of Maryland
Performance indicators will be identified and outlined in a contract between MHA and the University of Maryland.

CSAs
CSAs submit annual plans for each year, and annual reports when each year is over. MHA reviews the plans and reports. MHA also audits CSA contracts quarterly. MHA also attends monthly meetings with the CSAs.

MHA will be in regular communication with OHS regarding the waiver. If there are any concerns related to the 1915C PRTF waiver identified from MHA quarterly reviews of CSAs or any concerns identified at any time by MHA review of the CSAs, these concerns will be shared with Medicaid.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☑	☑	☑	☑
Assist individuals in waiver enrollment	☑	☑	☐	☑
Manage waiver enrollment against approved limits	☑	☑	☐	☐
Monitor waiver expenditures against approved levels	☑	☑	☐	☐
Conduct level of care evaluation activities	☑	☑	☑	☑
Review participant service plans to ensure that waiver requirements are met	☑	☑	☑	☐
Perform prior authorization of waiver services	☑	☑	☑	☐
Conduct utilization management functions	☑	☑	☑	☐
Recruit providers	☑	☑	☐	☐
Execute the Medicaid provider agreement	☑	☑	☐	☐
Determine waiver payment amounts or rates	☑	☑	☐	☐
Conduct training and technical assistance concerning waiver requirements	☑	☑	☑	☐

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○ **Mental Retardation or Developmental Disability, or Both**					
	☐	Autism			☐

	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
◉ **Mental Illness**					
	☑	Mental Illness	18	21	
	☑	Serious Emotional Disturbance	6	17	

b. Additional Criteria. The State further specifies its target group(s) as follows:

The target populations for the program are (1) children under 18 years of age with serious emotional disturbance (SED) and (2) youth aged 18 to 21 years with serious mental illness (SMI). Both populations must meet Maryland PRTF level of care. Children (under 18 years of age)and youth (18 to 21 years of age) do not have to be eligible for Medicaid or MCHP in the community.

In addition, participants must meet the following criteria: 1)have a plan of care that can be implemented in the community via the Maryland Wraparound Model; 2) have families who are residents of a geographical area where the Maryland Wraparound Model is available at the time the youth is identified; 3) the child or youth, along with their family members, choose to participate in the demonstration grant program instead of entering a PRTF or to enter the program and transition from the PRTF to the community; and 4) the applicant is not served in another 1915 (c) waiver. A prospective participant's residency is determined by the location of their primary home.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Prior to a participant's disenrollment, the team will develop a transition plan. The transition planning process will be part of the plan of care development throughout the course of a participant's enrollment.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage: ____

○ **Other**

Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The plan of care will define the needed services and will be used to assess the cost of serving individuals within the cost limit.

An applicant who is denied enrollment also receives a letter that provides information on their right to a fair hearing. As specified in COMAR 10.09.24.13(a), any applicant or their representative has the right to request a hearing if they believe an error was made in determining eligibility. A request for a hearing shall be made to the Department through a designated form within 90 days from the date the notice of action was mailed to the individual or their representative.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☑ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

On limited occasions someone may need to exceed the cost limit by a marginal amount. In these cases the care manager will alert the Mental Hygiene Administration to request approval for the marginal expenditure. All opportunities to revise the POC will be explored if a participant can no longer be served in a cost effective manner. For instance, if adding personal care hours pushes costs over the cost neutrality limit because the participant is less able to care for themselves, the use of assisted living services or residential habilitation services can be explored. The use of medical day care for 6 hours a day could also be considered. If an individual needs additional services for a temporary period of time, the Department can approve those services in order to continue to serve the individual in the program. If the period of time becomes more permanent (more than 4-6 months) or the costs threaten the overall cost neutrality of the program, the individual will be disenrolled.

☑ **Other safeguard(s)**

Specify:

In the event there is no solution available, the case manager will develop a discharge plan with the participant and representative/s, which may include referring the participant to AERS to provide detailed assistance in identifying non-waiver community resources and other support services. In addition, the waiver case manager may also refer the participant to the Information and Assistance service (I&A) at the local AAA. I&A staff also have expertise in identifying community resources and can provide certain financial benefit information if a participant is losing Medicaid eligibility as well. The Medicaid unit of the local department of social services is also a typical referral source when there are issues of Medicaid eligibility or planning needs to begin for financing long term care placement in a nursing facility. In some cases it is clearly evident that nursing facility placement is appropriate and acceptable to the participant and the case manager will provide guidance in how to locate a nursing facility in their community.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	87
Year 2	87

Year 3	124
Year 4 (renewal only)	124
Year 5 (renewal only)	448

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	75
Year 2	75
Year 3	100
Year 4 (renewal only)	100
Year 5 (renewal only)	400

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes
Community Medicaid/MCHP eligible children

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Community Medicaid/MCHP eligible children

Purpose *(describe):*

The state will reserve capacity for those children who are in families that meet the income and asset

standards for community eligibility for Medicaid or MCHP.

Describe how the amount of reserved capacity was determined:

Estimation of need.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	67
Year 4 (renewal only)	67
Year 5 (renewal only)	267

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ( ) **Waiver capacity is allocated/managed on a statewide basis.**
- (●) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

1. All children and youth currently being served in the four jurisdictions (Baltimore City, Montgomery County, St. Mary's County, and Wicomico County) will be screened for eligibility into the waiver based on established Maryland medical necessity criteria.

a. The only exception to this grandfathering clause will be if the total number of children and youth who are not community Medicaid eligible exceeds fifty (50); should this situation arise, the 50 slots will be allocated as follows: 18 slots to Baltimore City, 18 slots to Montgomery County, 7 slots to St. Mary's County, and 7 slots to Wicomico County.

b. Should any of the four jurisdictions not be able to fill the slots with children and youth currently being served at the start of the waiver services, those slots will become available for use by the other jurisdictions and will be allocated through a joint decision between the jurisdictions, the project director, and MHA.

2. For the slots remaining after all children and youth currently being served at the start of waiver services have

been screened for eligibility, the following allocation methodology will apply:

a. The total number of waiver slots remaining for both populations of children and youth(community Medicaid eligible and family of one) after all currently being served have been screened, will be divided among the four jurisdictions so that Baltimore City and Montgomery County each receive 35% of the remaining slots and St. Mary's County and Wicomico County each receive 15% of the remaining slots. These slots may be for either population of children and youth —community Medicaid eligible or Family of One.

b. A total of 50 slots must be reserved specifically for non-Community Medicaid eligible ("Family of One") children and youth who meet all other criteria.

c. At the discretion of the project director and MHA, a determination may be made to reallocate remaining slots if jurisdictions have waiting lists to serve eligible children and youth, and other jurisdictions are having difficulty in filling the slots. A jurisdiction may exceed their total allocation of waiver slots if they are able to serve a child or youth who is non-Community Medicaid eligible, if there are slots available.

d. The allocation formula will be reviewed at the end of the first year of the waiver and as needed and will be modified as appropriate by the project director and MHA.

The allocation formula was determined based on child population.

The Project Director with MHA will review allocation on an annual basis to determine distribution based on need. The State is in phase two of capacity-building in local jurisdictions and it is the hope that, over the course of the grant, all jurisdictions will be able to access services through the grant. However, at this point, only four jurisdictions will be participating in the grant.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry into the waiver is based upon the date of the applicant meeting all of the criteria for participation in the program: technical eligibility, medical eligibility and financial eligibility. Geographic distribution of slots and availability of slots for children and youth who are community-eligible for Medicaid or MCHP will also be taken into consideration.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

- (•) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

All other mandatory and optional groups under the plan are included except individuals eligible under medically needy groups.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

Select one:

- **100% of FPL**
- **% of FPL, which is lower than 100%.**

Specify percentage amount:

- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other**

    Specify:

    [ ]
- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

  [ ]

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**

- **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

  [ ]

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

  [ ]
- **Other**

  Specify:

  [ ]

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)**
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  Specify:

  [ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (•) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (•) **By an entity under contract with the Medicaid agency.**

Specify the entity:

Under contract with MHA, MAPS-MD convenes an independent team for review of the medical, psychiatric, and psychosocial evaluations. These evaluations are reviewed for level of care evaluations and reevaluations. The independent team convened by MAPS-MD includes a representative of the local Core Service Agency, as well as a MAPS-MD care coordinator, and a MAPS-MD physician.

- **Other**
  Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Medical, psychiatric, and psychosocial evaluations to assess medical eligibility for PRTF level of care are performed by licensed psychologists and physicians and are forwarded to MAPS-MD for an independent team review. The independent team convened by MAPS-MD includes a social worker or similar mental health professional at the local core service agency (local public or not-for-profit mental health agency), a MAPS-MD care coordinator, and a MAPS-MD physician. The independent team convened by MAPS-MD determines whether the child or youth meets medical eligibility (PRTF level of care).

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Initial Evaluation: The level of care criteria for the waiver are the same as the criteria for admission to PRTFs. The MAPS-MD manual has PRTF level of care guidance. The medical eligibility criteria to be met for PRTF level of care, as defined by the MAPS-MD manual, are two-fold: severity of need and intensity of service required. Both criteria must be met. Severity of need includes: 1) the child/ youth has a Public Mental Health System DSM-IV-TR diagnosis; 2) clinical evidence that the child/youth has a long-term and severe mental disorder; and, 3) due to the mental disorder the child/youth exhibits symptoms that represent severe risk of injury to self or others. Intensity of service criteria include: 1) medically necessary PRTF placement given that all less intensive levels of care have been determined to be either unsafe or unsuccessful; 2) the child/youth requires a 24 hours per day /seven days per week structured and supportive inpatient living situation; and, 3) an individual plan of active psychiatric treatment and residential living support is required.

In addition to the MAPS-MD manual guidance on level of care, additional information is gathered by licensed mental health providers from the CANS-Comprehensive and the CASII (Child and Adolescent Service Intensity Instrument) and is forwarded to MAPS-MD. The CANS has been adapted with assistance from its developer, John Lyons.
Six month reevaluation: In addition to meet continued medical eligibility, the following criteria must be met 1) evidence of the need for continued support 24 hours per day in a therapeutic living situation; 2) clinical evidence of therapeutic clinical goals that must be met before the individual can transition to a less intensive level of care; and, 3) clinical evidence of symptom improvement. The CANS and CASII are also administered again at this time by licensed mental health providers.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Applicants who are applying for the waiver will have their medical eligibility assessed by MAPS-MD, with the CSA on the independent team, at the time of application. They will be reevaluated every six months to ensure participants continue to meet medical eligibility criteria. Applicants who are applying for diversion from PRTF will be assessed in the same way.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

MAPS-MD uses a computerized system called "Care Connections". Care Connections triggers the reevaluation every twelve months.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

MHA stores all documentation related to evaluations and reevaluations in the waiver applicant's/ participant's permanent record, which is stored at the MHA headquarters for a minimum of three years.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants are informed about the services available under the waiver through a written brochure that is provided to them through the Local Coordinating Council (LCC), with guidance that the services detailed in the brochure are the types of services that are provided, and that all services provided will be specific to the individualized needs of the child or youth and their respective family. The care coordinator will have extensive information on the qualified providers and the specific services covered under the waiver and will also bring that information to the first Child/Youth and Family Team (CFT) meeting. As the plan of care is developed, there will be an ongoing conversation about the types of services that are available that may address each identified need.

Children and youth already in a PRTF will be informed about the waiver services through their LCC Lead Agency or the LCC Support Specialist.

During the eligibility process, the waiver applicant/ family will complete a Freedom of Choice form which requires the applicant to choose between institutional and community-based services. The application packet is not considered complete and the applicant will not be enrolled in the waiver until the Freedom of Choice form is signed.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed Freedom of Choice form, along with the other application forms, are stored for a minimum of three years in the participant's permanent waiver record located at MHA's office. Application forms, including the Freedom of Choice form, are also stored for a minimum of three years for those individuals who are determined not eligible for PRTF waiver services.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The state provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. MHA will provide interpreters at no cost to clients, and translations of forms and documents into languages spoken by a significant proportion of the population. Interpreter resources are available for individuals who contact DHMH for information, requests for assistance or complaints. Additionally, MHA actively recruits providers who speak languages other than English across the system.

The DHMH website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community. The State also provides translation services at fair hearings, if necessary. If an LEP appellant attends a hearing without first requesting services of an interpreter, the administrative law judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service	
Statutory Service	In-Home Respite	
Statutory Service	Supported Employment	
Other Service	Caregiver Peer-To-Peer Support	
Other Service	Experiential and Expressive Therapies	
Other Service	Family and Youth Training	
Other Service	Mobile Stabilization Support Service	
Other Service	Peer-To-Peer Support	
Other Service	Residential Respite	

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

In-Home Respite

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite Services are temporary care which is arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of care-giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a potential crisis situation. These services may be provided in the home or the community. The child or youth will be residing in his or her family home (biological or kin), legal guardian's home, pre-adoptive/adoptive, foster home, or treatment foster home when in-home respite services are provided.

****

"Respite care" means services that are:
(1) Provided on a short-term basis in a community-based setting; and
(2) Designed to support an individual to remain in the individual's home by:
(a) Providing the individual with enhanced support or a temporary alternative living situation, or
(b) Assisting the individual's home caregiver by temporarily freeing the caregiver from the responsibility of caring for the individual
(3) Designed to fit the needs of the individuals served and their caregivers; and
(4) Delivered by individuals who are enrolled by the program to provide a particular service.

A program may provide respite care services as needed for an individual based on the Child/Youth Family Team's Plan of Care. The Plan of Care should outline duration, frequency, location and be designed with a planned conclusion. It should include:
(1) A schedule of the individual's activities during respite,
(2) When needed, medication monitoring,
(3) The frequency and intensity of staff support,
(4) The respite locations, and
(5) The aftercare plan or recommendations.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Year 1: 86 days
Year 2: 58 days

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: In-Home Respite

Provider Category:
Agency
Provider Type:
Respite
Provider Qualifications

License *(specify):*
Qualifications:
• Must be licensed as a Psychiatric Rehabilitation Program (PRP), Outpatient Mental Health Clinic (OMHC), or Mobile Treatment.

• Must, at a minimum, meet the requirements for direct service care staff under the regulations for Psychiatric Rehabilitation Services for Minors (COMAR 10.21.29).

• The Respite Care Specialist (RCS) must be
o 21 years of age or older;
o approved by the family and Child Family Team; and,
o have a completed criminal history check that is approved by the CME Community Resource Manager.

• Agency-based RCS's will have met employment standards to be qualified to provider respite.

Certificate *(specify):*

Other Standard *(specify):*
Knowledge & Experience:
• Must meet educational and experience requirements as required by COMAR for PRP, OMHC, or Mobile Treatment.
• Knowledge of the child and family network expected.
• Approval by the primary caregiver and Child Family Team necessary.
• Ability to create a meaningful respite experience expected.

Program meets the Department's requirements for being an approved provider of respite services (outlined in COMAR 10.21.27).

A. The program director shall ensure that the staff is sufficient in numbers and qualifications to carry out the program's service goals
B. The governing body shall employ a program director who:
(1) Has sufficient qualifications, knowledge, and experience to execute the duties of the position;
(2) Is available to provide residential crisis services (RCS) administration and supervision:
(a) For the amount of time necessary to carry out the duties and, at a minimum, 10 hours per week; and
(b) If a program operates in more than one site, by:
(i) Designating, as necessary, staff to manage services at each site and report to the program director, and
(ii) Having contact with each site each week;
(3) Is responsible for operational oversight for, at a minimum:
(a) Fulfilling the administrative requirements under COMAR 10.21.17 and the day-to-day operations of the RCS program;
(b) Maintaining sufficient staff, including recruiting, hiring, scheduling, and terminating;

(c) Consulting on the development and implementation of the budget;
(d) Keeping the governing body informed of, at a minimum, the program's approval status and performance; and
(e) In collaboration with appropriate staff, assuring staff compliance with:
(i) Credentialing and privileging,
(ii) Appropriate training and supervision, and
(iii) When required, the on-call availability of a psychiatrist; and
(4) If appropriately credentialed and privileged, may provide services.
C. The program director shall assign to each individual who is receiving RCS a treatment coordinator who shall provide or coordinate the services outlined in this chapter for the specific type and level.
D. Direct Service Providers. The program director shall employ a sufficient number of direct service providers who:
(1) As determined by the program, have sufficient qualifications and experience to carry out the duties of the position;
(2) Before providing services, have training applicable to the service, including, at a minimum, training in:
(a) Crisis intervention,
(b) Suicide prevention,
(c) Behavior modification, and
(d) Family interactions; and
(3) As permitted under the Health Occupations Article, Annotated Code of Maryland, and as privileged by the program, provide the level and intensity of supervision and support required under this chapter for the specific type and level of RCS indicated in an individual's plan of care.

Provider Qualifications

Entity Responsible for Verification:
Mental Health Administration
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supported Employment provides employment support services to individuals for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These services are provided to enable eligible individuals to choose, obtain, or maintain individualized, competitive employment, in an integrated work environment, consistent with their interests, preferences, and skills.

Documentation is maintained in the file of each participant receiving this service

that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

****

Supported Employment Services are provided by a Mental Health Vocational Program approved under Maryland Law (COMAR 10.21.28). Supported Employment provides ongoing, time unlimited employment support services to individuals with serious mental illness (SMI) for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These services are provided to enable eligible individuals to choose, obtain, or maintain individualized, competitive employment, in an integrated work environment, consistent with their interests, preferences, and skills (MAPS-MD).

"Supported employment program" means a program designed to assist an individual to obtain competitive employment in an integrated work environment that provides:
(a) Compensation to individuals of at least minimum wage;
(b) An individualized approach that establishes an hours-per-week employment goal to maximize an individual's vocational potential;
(c) Additional supports, as needed, delivered where appropriate; and
(d) Transitional employment placements which means a series of planned temporary, sequential job placements, with continuous support services, provided to an individual in the public mental health system until job permanency is achieved. Transitional services are integrated with the youth's IEP when applicable.

The SE service, funded under the Public Mental Health System (PMHS), consists of four reimbursable service phases:
1) Pre-placement Phase, which includes, at a minimum, MHVP Assessment, referral to the Division of Rehabilitation Services (DORS) and entitlements counseling, and discussion of the risks and benefits of disability disclosure and informed choice.
2) Placement in a Competitive Job (does not include agency-sponsored employment), which includes assisting the consumer in negotiating with the employer a mutually acceptable job offer and advocating for the terms and conditions of employment, to include any reasonable accommodations and adaptations requested by the individual.
3) Intensive Job Coaching Phase (usually reimbursed from DORS), which includes systematic intervention techniques to help the supported employee learn to perform job tasks to the employer's specifications and to learn the interpersonal skills necessary to assume the employee role and to be accepted as an employee worker at the job site and in related community-based settings. Job coaching may also be used as a preventative intervention-to assist the individual in preserving the placement, resolving employment crises, and in stabilizing the employment situation for continuing employment. In addition to direct job skills training, job coaching includes related assessment, counseling, advocacy, mobility skills training and other support services as needed to promote job stability and social integration within the employment environment.
4) Extended Support Services Phase, which includes proactive employment advocacy, counseling, and support services at or away from the job site to assist the individual to maintain continuous, uninterrupted competitive employment and to develop an employment-related support system, to include encouraging the use of natural supports, to the maximum extent possible. This service is time unlimited and continues until the individual no longer requests the service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Lifetime maximum of $2,750 for intensive job coaching.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Supported Employment
Provider Qualifications

License *(specify):*
Qualifications: Supported Employment provider must
• Be at least 21 years of age;
• have knowledge and ability to assess job readiness, job coaching and job supervision;
• have an ability to create job opportunities for youth with limited employment experiences; and,
• understand the tenets of supported employment and how to apply them to young adults.

Certificate *(specify):*

Other Standard *(specify):*
Knowledge & Experience:
• No educational requirement needed; however, previous work experience in delivering supported work necessary.
• Minimum training for provider to include completion of a 6 hour supported employment training with approved certificate by an approved supported employment training vendor.

Program meets the Department's requirements for being an approved provider of supported employment services (outlined in COMAR 10.21.28).

A. The program director shall ensure that the staff is sufficient in numbers and qualifications to carry out the program's service goals
B. The governing body shall employ a program director who:
(1) As determined by the governing body, has sufficient qualifications, knowledge, and experience to execute the duties of the position;
(2) Is available to provide SE administration and supervision:
(a) For the amount of time necessary to carry out the duties and, at a minimum, 10 hours per week; and
(b) If a program operates in more than one site, by:
(i) Designating, as necessary, staff to manage services at each site and report to the program director, and
(ii) Having contact with each site each week;
(3) Is responsible for operational oversight for, at a minimum:
(a) Fulfilling the administrative requirements under COMAR 10.21.17 and the day-to-day operations of the SE program;
(b) Maintaining sufficient staff, including recruiting, hiring, scheduling, and terminating;
(c) Consulting on the development and implementation of the budget;
(d) Keeping the governing body informed of, at a minimum, the program's approval status and performance; and

(e) In collaboration with appropriate staff, assuring staff compliance with:
(i) Credentialing and privileging,
(ii) Appropriate training and supervision, and
(iii) When required, the on-call availability of a psychiatrist; and
(4) If appropriately credentialed and privileged, may provide services.
C. The program director shall assign to each individual who is receiving SE a treatment coordinator who, as privileged by the program, shall provide or coordinate the services outlined in this chapter for the specific type and level.
D. The program director shall employ a sufficient number of direct service providers who:
(1) As determined by the program, have sufficient qualifications and experience to carry out the duties of the position;
(2) Before providing services, have training applicable to the service, including, at a minimum, training in:
(a) Crisis intervention,
(b) Suicide prevention,
(c) Behavior modification, and
(d) Family interactions; and
(3) As permitted under the Health Occupations Article, Annotated Code of Maryland, and as privileged by the program, provide the level and intensity of supervision and support required under this chapter for the specific type and level of SE indicated in an individual's ITP

Provider Qualifications

Entity Responsible for Verification:
Mental Health Administration
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Caregiver Peer-To-Peer Support

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Caregiver Peer-To-Peer Support delivered by a Family Support Partner will:

• Explain role and function of the Family Support Organization (FSO) to newly enrolled Care Management families.
• Work with the family to identify and articulate their concerns and needs
• Ensure family voice is incorporated into Child/Youth Family Team process and Plan of Care through communication with Care Manager and Team Members.
• Accompany the family to Child/Youth Family Team meetings to support family voice and choice.
• Listen to the family express needs and concerns from peer perspective and offer suggestions for engagement in Care Management process.
• Provide ongoing emotional support, modeling and mentoring during all phases of the Child/Youth Family Team

process.
• Help family identify and engage natural support system and other community resources.
• Facilitate the family attending peer group and other FSO activities throughout POC process.
• Work with the family to organize, and prepare for meetings in order to maximize the family's participation in meetings
• Support family in meetings at school and other locations in the community and during court hearings.
• Empower family to make choices to achieve desired outcomes for their child or youth,as well as the family.
• Help the family acquire the skills and knowledge needed to attain self-efficacy.
• Along with a Care Manager and Youth Support Partner make a joint engagement visit (within 72 hours) to families enrolled in Care Management. If this is not possible, Family Support Partner and Youth Support Partner will make separate visits.
• Notify Care Manager of critical incidents and when they are no longer involved with families. Care Manager will timely notify Family Support Partners of team meetings, rescheduled meetings, and critical incidents.

The following activities are provided to families who request FSO services:

• Assistance in understanding all phases of the Child/Youth Family Team process and in communicating family needs to Care Manager and Team Members.
-- Supporting, modeling and coaching families to help with their engagement in Care Management process;
-- Community resource linkage;
-- Support during meetings at school and other locations in the community and during court hearings.
-- Linkage to peer network
-- Information and education on procedures to access services and, if needed, assistance with securing needed services.
-- Consultation, if needed, to Care Managers on ISP management after discussion with families.
-- Planning for transition from the Child/Youth Family Team process to ensure continued success.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Year 1: 124 days
Year 2: 84 days

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Caregiver Peer-To-Peer Support

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver Peer-To-Peer Support

Provider Category:
Agency
Provider Type:
Caregiver Peer-To-Peer Support
Provider Qualifications
License *(specify):*

Qualifications:
• Caregiver (current or previously) of a child or youth with intensive needs
• Minimum 21 years old
• Ability and willingness to provide educational and advocacy supports to caregivers

Certificate *(specify):*
Wrap Around Practitioner Certificate

Over the course of one year applicants will need to meet certain requirements in order to receive certification. These requirements include:
• Completion of a series of 10 training modules
• Participation in on-site monthly coaching sessions from INNOVATIONS INSTITUTE trainer/coach
• Participation in weekly supervision
• Completion of the Professional Development and Supervision Worksheet on a weekly basis. One worksheet will be collected per month to show growth and skill acquisition.
• Completion of 3 Child and Family Team (CFT) observations utilizing the Wraparound Fidelity Assessment System's Team Observation Measure (collected every 4 months) for Care Coordinators and the Family Support Partner (FSP) Observation Measure for Family Support Partners. One observation will be conducted by Innovations Institute trainer/coach.
• Completion of 3 Documentation Review Measures (collected every 4 months) for Care Coordinators. One Documentation Review Measure will be completed by INNOVATIONS INSTITUTE trainer/coach. (This does not apply to Family Support Partner Certification.)

(As this process occurs over the course of one year, the individual does not have to be certified as a wraparound practitioner at the start of service provision but rather needs to be enrolled in the certificate course.)

Other Standard *(specify):*
Knowledge & Experience
• Caregiver (current or previously) of a child or youth with intensive needs
• Completion of Wraparound Practitioner Certificate
• Theoretical knowledge (child development, basic mental health symptoms and diagnoses, and basic treatments for children's mental health)
• Systems of care expertise
• Family support skills
• Knowledge of laws and policy (basic Special Education, Medicaid, private insurance, legislative process, and state and local policy development)
• Cultural competence knowledge and skills
• Communication skills
• Organizational skills
• Advocacy skills

A family member within the Family Support Organization is an individual who has experience raising a child with a complex emotional/behavioral and mental health challenge, being the caretaker and the main decision maker for that child, and having had to negotiate services and supports for that child. This may include but not be limited to a birth parent, stepparent, adoptive parent, foster parent, grandparent, aunt, uncle or adult sibling of a child with complex emotional/behavioral and mental health challenges.

Peer support providers must receive Mental Hygiene Administration-approved training and be approved as a provider by the Mental Hygiene Administration.

Provider Qualifications

Entity Responsible for Verification:
Mental Health Administration

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Experiential and Expressive Therapies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Expressive Therapy involves action on the part of the therapist and the consumer and is a subset of Experiential Therapy. This includes understanding of psychotherapeutic systems at both nonverbal and a verbal level as necessary in exploring the developmental properties inherent in the art process. Expressive therapy is a group of techniques that are expressive and creative in nature. The aim of creative therapies is to help consumers find a form of expression beyond words or traditional therapy, such as cognitive or psychotherapy.

Expressive therapy includes techniques that can be used for self-expression and personal growth when the client is unable to participate in traditional "talk therapy," or when that approach has become ineffective.

Experiential and Expressive Therapies will include:

• Art Therapy
• Music Therapy
• Dance/Movement Therapy
• Psychodrama/Drama Therapy
• Narrative
• Writing (Biblio and Poetry) Therapy
• Photo Therapy
• Mind/Body Therapy
• Activity Therapy
• Recreational Therapy
• Play Therapy
• Adventure Therapy
• Animal Assisted Therapy
• Horticultural Therapy

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Year 1: 115 hours
Year 2: 77 hours

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Board Certified Therapeutic Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Experiential and Expressive Therapies

Provider Category:
Individual
Provider Type:
Board Certified Therapeutic Provider
Provider Qualifications
License *(specify):*
Board Certified Therapeutic Provider
Certificate *(specify):*
Board certified under specific therapeutic discipline.
Other Standard *(specify):*
Individuals shall have a Master's degree in a relevant discipline, such as social work, counseling, psychology or psychiatry.
Provider Qualifications
Entity Responsible for Verification:
Mental Health Administration
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Family and Youth Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Family and Youth Training shall be provided as specified in the participants Plan of Care (POC) through the Child/Youth and Family Team Process. Family and Youth Training may include, but is not limited to:
--Individual and group training on diagnosis,
--Medication management,
--Treatment regimens including Evidence Based Practices,
--Behavior planning, intervention development, and modeling,
--Skills training,
--Systems mediation and self advocacy
--Finance Management
--Socialization

--Individualized Education Planning
--Systems Navigation

Training normally involves a curriculum or defined set of experiences which will promote usable learning and skill development.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
144 hours over a one year period

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family and Youth Training Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family and Youth Training

Provider Category:
Agency
Provider Type:
Family and Youth Training Provider
Provider Qualifications

License *(specify):*
Appropriate licensing to provide identified Family and Youth Training Modules.
Certificate *(specify):*
Appropriate certification to provide identified Family and Youth Training Modules. Wraparound Practitioner Certification will be accepted.

Family Trainers:

• Completion of a series of 10 training modules
• Participation in on-site monthly coaching sessions from INNOVATIONS INSTITUTE trainer/coach
• Participation in weekly supervision
• Completion of the Professional Development and Supervision Worksheet on a weekly basis. One worksheet will be collected per month to show growth and skill acquisition.
• Completion of 3 Child and Family Team (CFT) observations utilizing the Wraparound Fidelity Assessment System's Team Observation Measure (collected every 4 months) for Care Coordinators and the Family Support Partner (FSP) Observation Measure for Family Support Partners. One observation will be conducted by Innovations Institute trainer/coach.
• Completion of 3 Documentation Review Measures (collected every 4 months) for Care Coordinators. One Documentation Review Measure will be completed by INNOVATIONS INSTITUTE trainer/coach. (This does not apply to Family Support Partner Certification.)

(As this process occurs over the course of one year, the individual does not have to be certified as a wraparound practitioner at the start of service provision but rather needs to be enrolled in the certificate course.)

Other Standard *(specify):*
Youth Trainers
Qualifications:
• Minimum 18 years old
• Minimum education of a GED or high school diploma
• Experience providing training to youth
• Completion of Wraparound 101, Crisis Planning, CANS, and Systems of Care 101 trainings, along with a series of mini-trainings offered through the Innovations Institute on topics such as leadership development, communication skill enhancement, cultural and linguistic competence, healthy relationships, mediation and effective decision-making, transitioning into changing roles, mapping and navigating the course, and support and advocacy.

Youth Trainers - Knowledge & Experience:
• Theoretical knowledge (child development, basic mental health symptoms and diagnoses, and basic treatments for children's mental health)
• Systems of care expertise
• Youth support skills
• Knowledge of laws and policy (basic Special Education, Medicaid, private insurance, legislative process, and state and local policy development)
• Cultural competence knowledge and skills
• Communication skills
• Organizational skills
• Advocacy skills
• Co-trainer with an experienced lead trainer for a minimum of 6 months

Family Trainers
Qualifications:
• Completion of Wraparound Practitioner Certificate
• Associate's or Bachelor's Degree
• Minimum 21 years old
• Employed by a family organization in the system providing peer-to-peer support for a minimum of 3 years

Family Trainers - Knowledge & Experience:
• Theoretical knowledge (child development, basic mental health symptoms and diagnoses, and basic treatments for children's mental health)
• Systems of care expertise
• Family support skills
• Knowledge of laws and policy (basic Special Education, Medicaid, private insurance, legislative process, and state and local policy development)
• Cultural competence knowledge and skills
• Communication skills
• Organizational skills
• Advocacy skills
• Co-trainer with an experienced lead trainer for a minimum of 6 months

Provider Qualifications

Entity Responsible for Verification:
Mental Health Administration
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Mobile Stabilization Support Service

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Mobile Stabilization Support services are interventions that provide parents/caregivers/guardians with short-term, flexible services that assist in stabilizing children/youth in their home/community setting. Interventions are designed to maintain the child/youth in his/her current living arrangement, to prevent movement from one living arrangement to another and to prevent repeated hospitalizations. Interventions at this level of care include the delivery of a flexible variety of services through the development of a comprehensive and coordinated Individual Crisis Plan (ICP) with entry being part of the youth's POC. This service is differs from the State Plan service in terms of its intensity and the type of providers offering services. MSSS will incorporate a team model to include a clinician supervisor and therapeutic aide, who is an individual with a bachelor's degree in a human services field. MSSS providers must meet with the child/youth at least three times per week for the first two weeks of service provision, at least twice each week for the subsequent two weeks of service provision, and at least once a week for the duration of services.

Interventions must be coordinated with the youth's primary therapist and may include crisis intervention, counseling, behavioral assistants, in-home therapy, skill building, mentoring, medication management and/or parent/caregiver/guardian stabilization interventions. Mobile stabilization is pre-authorized and reviewed by MAPS-MD. These interventions can be used up to eight weeks. Use of these interventions will vary by setting, intensity and duration.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Year 1: 144 hours
Year 2: 96 hours

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Mobile Stabilization Support Service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Mobile Stabilization Support Service

Provider Category:

Agency

Provider Type:

Mobile Stabilization Support Service

Provider Qualifications

License *(specify):*

Qualifications:

• The clinical supervisor must

o be licensed in good standing under Health Occupations Article, Annotated Code of Maryland, as a psychiatrist, social worker, registered nurse, or mental health professional;

o be able to provide supervision;

o be at least 21 years old; and,

o have a completed criminal history check that is approved by the CME Community Resource Manager.

Certificate *(specify):*

Other Standard *(specify):*

• The therapeutic aide must

o be at least 21 years old;

o have a bachelor's degree in a human services field;

o have a completed criminal history check that is approved by the CME Community Resource Manager; and,

o have completed training in crisis planning and resolution within the first 6 months of employment.

Meets requirements for the Department's approval to provide mobile stabilization support services.

A. The program director shall ensure that the staff is sufficient in numbers and qualifications to carry out the program's service goals

B. The governing body shall employ a program director who:

(1) As determined by the governing body, has sufficient qualifications, knowledge, and experience to execute the duties of the position;

(2) Is available to provide ISS administration and supervision:

(a) For the amount of time necessary to carry out the duties and, at a minimum, 10 hours per week; and

(b) If a program operates in more than one site, by:

(i) Designating, as necessary, staff to manage services at each site and report to the program director, and

(ii) Having contact with each site each week;

(3) Is responsible for operational oversight for, at a minimum:

(a) Fulfilling the administrative requirements under COMAR 10.21.17 and the day-to-day operations of the ISS program;

(b) Maintaining sufficient staff, including recruiting, hiring, scheduling, and terminating;

(c) Consulting on the development and implementation of the budget;

(d) Keeping the governing body informed of, at a minimum, the program's approval status and performance; and

(e) In collaboration with appropriate staff, assuring staff compliance with:

(i) Credentialing and privileging,

(ii) Appropriate training and supervision, and

(iii) When required, the on-call availability of a psychiatrist; and

(4) If appropriately credentialed and privileged, may provide services.

C. The program director shall assign to each individual who is receiving ISS a treatment coordinator who, as privileged by the program, shall provide or coordinate the services outlined in this chapter for the specific type and level.

D. The program director shall employ a sufficient number of direct service providers who:

(1) As determined by the program, have sufficient qualifications and experience to carry out the duties of the position;

(2) Before providing services, have training applicable to the service, including, at a minimum, training in:

(a) Crisis intervention,

(b) Suicide prevention,
(c) Behavior modification, and
(d) Family interactions; and
(3) As permitted under the Health Occupations Article, Annotated Code of Maryland, and as privileged by the program, provide the level and intensity of supervision and support required under this chapter for the specific type and level of ISS indicated in an individual's ITP

Provider Qualifications

Entity Responsible for Verification:
Mental Health Administration
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Peer-To-Peer Support

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Peer-To-Peer Support delivered by a Youth Support Partner will:
• Provide explanation of role and function of Youth Support to newly enrolled families
• Ensure youth voice is incorporated into planning process through communication with Care Coordinator and Family Support Partner
• Work with the youth to articulate their own needs and concerns
• Encourage and support youth in participating and guiding the Child/Youth Family Team process
• Listen to youth needs, concerns from peer perspective, offering suggestions for engagement in Care Management process
• Provide assistance in understanding plan of care process and in communicating youth needs to Child/Youth Family Team (CFT)
• Provide consultation, if needed, with CFT regarding planning process after discussion with youth
• Accompany youth to CFT meetings or other meetings as needed for support
• Provide ongoing emotional support for youth to engage in CFT process
• Support youth in preparing for CFT meetings
• Help educate the youth about the systems he or she is involved with
• Help youth identify and engage natural support systems and other community resources
• Encourage, refer youth to attend peer group and other youth activities throughout planning process
• Link youth to community resources and a peer network
• Linkage to youth leadership development opportunities
• Provide assistance planning for transition out of Care Management
• Facilitate the youth attending youth activities
• Empower the youth to make choices in a way that is developmentally appropriate in order to guide the team process
• Help the youth acquire the skills and knowledge needed to attain resiliency

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Year 1: 30 days
Year 2: 20 days

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Peer Support Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer-To-Peer Support

Provider Category:
Agency
Provider Type:
Certified Peer Support Provider
Provider Qualifications
License *(specify):*
Provider Qualifications:

Minimum 18 years old
Minimum education of a GED or high school diploma
Experience providing training to youth
Completion of Wraparound 101, Crisis Planning, CANS, and Systems of Care 101 trainings, along with a series of mini-trainings offered through the Innovations Institute on topics such as leadership development, communication skill enhancement, cultural and linguistic competence, healthy relationships, mediation and effective decision-making, transitioning into changing roles, mapping and navigating the course, and support and advocacy.
Certificate *(specify):*

Other Standard *(specify):*
A Youth Support Partner is a young adult who has experienced the youth serving systems as a consumer who has had emotional/behavioral and mental health challenges. The Youth Support Partner should be prepared to support other youth, be able to share personal experiences as a consumer, be able to advocate for youth, and have a significant understanding about the structure and operations of youth serving systems. The Youth Support Partner must have Mental Hygiene Administration-approved training and by approved by the Mental Hygiene Administration to be a provider.

Provider Knowledge & Experience:

Theoretical knowledge (child development, basic mental health symptoms and diagnoses, and basic treatments for children's mental health)
Systems of care expertise

Youth support skills
Knowledge of laws and policy (basic Special Education, Medicaid, private insurance, legislative process, and state and local policy development)
Cultural competence knowledge and skills
Communication skills
Organizational skills
Advocacy skills
Co-trainer with an experienced lead trainer for a minimum of 6 months

Provider Qualifications

Entity Responsible for Verification:
Mental Health Administration
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Residential Respite

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite Services are temporary care which is arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of care-giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a potential crisis situation. Out-of-home respite is provided in a facility that is appropriately licensed, registered, or approved, based on:
(a) The age of individuals receiving services, and
(b) Whether the respite has capacity to do overnight services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
144 days

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Respite

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Residential Respite

Provider Category:
Agency
Provider Type:
Residential Respite
Provider Qualifications

License *(specify):*
Qualifications, Knowledge & Experience
Must be licensed, have a rate from the Interagency Rates Committee, and have a contract to provide respite care to youth in an oversight capacity, in accordance with COMAR 14.31.05-07 and 10.21.27.
Certificate *(specify):*

Other Standard *(specify):*
Program meets the Department's requirements for being an approved provider of respite services (outlined in COMAR 10.21.27).

A. The program director shall ensure that the staff is sufficient in numbers and qualifications to carry out the program's service goals
B. The governing body shall employ a program director who:
(1) As determined by the governing body, has sufficient qualifications, knowledge, and experience to execute the duties of the position;
(2) Is available to provide residential crisis services (RCS) administration and supervision:
(a) For the amount of time necessary to carry out the duties and, at a minimum, 10 hours per week; and
(b) If a program operates in more than one site, by:
(i) Designating, as necessary, staff to manage services at each site and report to the program director, and
(ii) Having contact with each site each week;
(3) Is responsible for operational oversight for, at a minimum:
(a) Fulfilling the administrative requirements under COMAR 10.21.17 and the day-to-day operations of the RCS program;
(b) Maintaining sufficient staff, including recruiting, hiring, scheduling, and terminating;
(c) Consulting on the development and implementation of the budget;
(d) Keeping the governing body informed of, at a minimum, the program's approval status and performance; and
(e) In collaboration with appropriate staff, assuring staff compliance with:
(i) Credentialing and privileging,
(ii) Appropriate training and supervision, and
(iii) When required, the on-call availability of a psychiatrist; and
(4) If appropriately credentialed and privileged, may provide services.
C. The program director shall assign to each individual who is receiving RCS a treatment coordinator who, as privileged by the program, shall provide or coordinate the services outlined in this chapter for the specific type and level.
D. The program director shall employ a sufficient number of direct service providers who:
(1) As determined by the program, have sufficient qualifications and experience to carry out the duties of the position;
(2) Before providing services, have training applicable to the service, including, at a minimum, training in:
(a) Crisis intervention,
(b) Suicide prevention,
(c) Behavior modification, and

(d) Family interactions; and
(3) As permitted under the Health Occupations Article, Annotated Code of Maryland, and as privileged by the program, provide the level and intensity of supervision and support required under this chapter for the specific type and level of RCS indicated in an individual's plan of care.

Provider Qualifications

Entity Responsible for Verification:
Mental Hygiene Administration
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).**
    Complete item C-1-c.
  - ☑ **As an administrative activity.** *Complete item C-1-c.*
- ○ **None of the above apply** (i.e., case management is furnished as a waiver service)

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management will be delivered by a limited number of private case management entities that are selected through a competitive bid process.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

As specified in COMAR 10.09.56.04L(1), job applicants must submit an application to the Department of Public Safety and Correctional Services (DPSCS) for a child care criminal history background check (CHC). In accordance with Family Law Article, section 5-561, child care background checks result in both a state and FBI report.
There are multiple State laws and regulations governing the requirement for criminal history and background checks for individuals working or volunteering with or sheltering children and youth. Among these are:
• Family Law Article, §5-534, Annotated Code of Maryland and COMAR 07.02.09.05 —Requirements for

criminal background checks and disclosure for adults residing with children in family kinship settings
• Family Law Article, §§5-327(b) and 5-501—5-521, Annotated Code of Maryland. Agency (Note: Federal Regulatory Reference: 45 CFR §§228.13 and 228.42) and COMAR 07.05.01.09—Requirements for licensure as a private child placement agency for the screening of employees, volunteers, and governing board members
• Health-General Article, § 19-308, Annotated Code of Maryland and COMAR 10.07.14.15—Requirements for assisted living manager in residential treatment centers for children and adolescents with serious emotional disturbances
• Health-General Article, §§2-104(b), 15-103, and 15-105, Annotated Code of Maryland and COMAR 10.09.53.03—Requirements for private duty nursing
• Health-General Article, §§2-104(b), 15-103, 15-105, and 15-132, Annotated Code of Maryland and COMAR 10.09.54.04—Requirements for personal care agencies participating in the Home and Community Based Services Waiver for Older Adults
• Health-General Article, §§2-104(b), 15-103, 15-105, and 15-130, Annotated Code of Maryland and COMAR 10.09.56.04—Requirements for individuals working with children through the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder Health-General Article, §§2-104, 14-206, and 14-304, Annotated Code of Maryland and COMAR 10.12.04.13—Requirements for providing day care for the elderly and adults with a medical disability
• Health-General Article, §7-904, Annotated Code of Maryland and COMAR 10.22.02.11—Requirements for licensees of the Developmental Disabilities Administration
• Health-General Article, §§8-401—8-405 and 19-308, Annotated Code of Maryland and COMAR 10.47.01.03—Requirements for programs under the Alcohol and Drug Abuse Administration
• Education Article, §§2-205, 2-206, 2-304, 7-301, 7-302, and 7-405; Family Law Article, §§5-561 and 5-704; Annotated Code of Maryland and COMAR 13A.09.09.04—Requirements for Education Programs in Nonpublic Schools
• Family Law Article §§5-550—5-557.1 and 5-560; State Government Article, §10-617; Article 88A, §6(b); Annotated Code of Maryland; Agency Note: Federal Statutory Reference—Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.) Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) and COMAR 13A.14.01.02 and .05—Requirements for Family Day Care providers
• Article 41, §§6-101 and 6-104; Article 83C, §§2-102, 2-104, 2-113, 2-120, and 2-123—2-125; Education Article, §§8-301—8-303 and 8-401—8-417; Family Law Article, §§5-506, 5-508, 5-509, and 5-510; Health-General Article, §§2-104, 7-904, 8-404, 10-922, and 10-924; Annotated Code of Maryland and COMAR 14.31.01.06—Requirements for residential child care programs
• Article 41, §§6-101 and 6-104; Article 83C, §§2-102, 2-104, 2-113, 2-120, and 2-123—2-125; Education Article, §§8-301—8-303; Family Law Article, §§5-506, 5-508, 5-509, 5-509.1, and 5-510; Health-General Article, §§2-104, 7-904, 8-404, 10-922, and 10-924; Annotated Code of Maryland and COMAR 14.31.01.07—Specialized licensing standards for residential child care programs
• Article 83C, §2-122, Annotated Code of Maryland and COMAR 16.17.01.04—Requirements for Youth Services Bureaus providing nonresidential community services
OHCQ, as regulatory oversight body for DHMH, would ensure that the required documentation (i.e. a copy of the records/history check) is in the individual's personnel file. MHA will determine the documentation is in place prior to enrolling providers.

Agencies are required to pay for their direct care workers to have child care criminal history checks and that information must be kept on file. COMAR 10.09.54.04 specifies the types of crimes that would disqualify a job applicant and also provides guidelines on how to handle applicants whose crimes were committed prior to 10 years ago. Agencies are monitored to ensure that criminal background checks are on file.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- **No. The State does not conduct abuse registry screening.**
- **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver*

service for which payment may be made to relatives/legal guardians.

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Maryland will follow the current enrollment process: Providers who are programs are licensed through OHCQ and then the Program obtains a Medicaid number. Other providers must meet the requirements of regulation. Providers then contacts MAPS-MD to "enroll" in the CareConnection authorization system, and to obtain other provider information regarding claims submission and claim payment. Providers will be recruited by the CME as soon as waiver is approved.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Case manager, called the care coordinator, facilitates the Child/Youth Family Team's process and activities. Care coordinator qualifications: Bachelor's in social work, psychology, nursing, or a related field, with experience in human services.

☐ **Social Worker.**
Specify qualifications:

☑ **Other**
Specify the individuals and their qualifications:

Service plan (plans of care) are developed by the Child/Youth Family team. Membership of the team includes: care manager (facilitates the Child/Youth Family Team), child or youth, parent(s), support persons identified by the family, Family Support Partner, and providers (determined by the child or youth's needs/ problems).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

  The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

During the development of the plan of care, family members and other supports identified by the family also participate as a part of the team. A Family Support Partner is assigned to the team to provide support and information to the family from a family perspective. All information shared during the plan of care process is shared with the family. The child/youth, along with their family, specify who they want on the Child/Youth Family Team (the group that is responsible for developing and revising the plan of care) in terms of family, friends, providers. These participants may change as the child's or youth's needs change particularly as he/she is transitioning out of the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

After enrollment in the waiver, the child's or youth's family is contacted within 24 hours. Within 72 hours of referral to the waiver, the care manager schedules a face to face meeting with the child or youth and his/her family to develop the initial crisis plan and begin the needs assessment. The Child/Youth Family Team meets as a group within 15 days to begin developing the care plan. Within 30 days, there is a plan of care developed for the child/ youth and their family.
(a) The plan of care is developed by the Child/Youth Family Team. Membership of the team includes: care manager, child or youth, parent(s), support persons identified by the family, Family Support Partner, providers (determined by the child's or youth's needs/ problems). The Team meets monthly and the plan is updated monthly. Minutes are taken at every meeting and are shared monthly with team members including the family. Additionally, there are copies in the child's or youth's file.

(b) There are a variety of assessments used to develop the plan. Information collected during the application process including physical examination, psychosocial and psychiatric evaluations are used. Additionally, the CANS-Comprehensive is administered every 90 days and the CASII (Child and Adolescent Service Intensity Instrument) at admission and every six months thereafter. Information from the family and their identified supports

is incorporated as a part of the process.

(c) The child's/youth's family is informed verbally and in writing about overall services available in the waiver at the time they make the choice between enrolling in the waiver and institutionalization. The specific services for each child or youth are an outcome of the development of the plan of care and team and family driven.

(d) The participant (child or youth and family) are integral members of the Child/Youth Family Team. Additionally, the Family Support Partner is there to support them in assuring that their voices are heard, and addresses participant goals, needs, and preferences. One of the goals of the waiver is for the family to learn how to facilitate the team to reach their goals.

(e) Implementation of the plan of care (waiver and other services) are coordinated by the team and the care coordinator. The Team meets at least monthly to review and revise the plan as needed. There is a formal plan review every 90 days with the entire team as well as an administration review.

(f) The plan of care development process and structure identifies who the responsible person(s) is(are) for each of the outcomes in the plan.
(g) The plan of care is reviewed monthly by the Child/Youth Family Team with minutes sent to members. There is a formal 90 day review of the plan. Updates/ revisions can occur at any time based on the child's or youth's needs and progress.

The Wraparound planning process incorporates all life domains into the POC development. The first step in developing an initial POC is to conduct the Child and Adolescent Needs Survey which helps guide planning. This tool would identify major areas of need for the parent(s) or legal guardian and family and youth. In addition, primary care, dental, and other medical concerns are always including in the POC development. Caregivers and youth (depending on age or cognitive development) are always at the table for the development of the POC. One of the key philosophies in the Wraparound process is Family-driven and youth-guided care. This means that parent(s) or legal guardian and family members are the primary decision makers in the care of their family with the support of the child or youth and parent(s) or legal guardian and family team.

There are specific time frames around POC development. Care coordinators are required to meet with the parent(s) or legal guardian and family to develop a crisis plan within 72 hours. This crisis plan can be used as an intermediate POC. If there are any immediate needs that must be addressed before the POC is developed in 30 days, the crisis plan development will allow emergency services to be engaged immediately. The care coordinator manages the POC process and the implementation. The Care Coordinator's supervisor reviews all POCs in addition to fidelity coaching provided by Innovations Institute, the Wraparound Fidelity Assessment also conducted by Innovations Institute, and the oversight by the Local Management Board around program monitoring. Families also have a family support partner who works in partnership with the care management entity to ensure that the family's needs are being met through Wraparound and to empower the family to be their own advocate for quality services and supports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

A part of the eligibility determination process is to ascertain if the child's or youth's needs can be met in the community using waiver services. If the child or youth cannot be served in the community, then he/she would be served in a PRTF.

Potential risks to participants are assessed by the applicant's treatment team (in the PRTF they are referred from including the treating physician), the community waiver provider, and the case manager prior to enrollment in the program through review of medical documentation and a face-to-face assessment of the waiver applicant. The identified health and safety risks and the medical and behavioral supports that are needed to support the participant safely in the community are documented in the plan of care and reviewed during the Child/Youth Family Team

meetings. Specific strategies for dealing with each identified risk are reflected in the plan of care. The plan includes emergency back up plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

MHA (MAPS-MD) will have a data-base and/ or directory available to the Child/Youth Family Team from which to choose providers to implement the plan of care. Providers are selected by the Child/Youth and Family Team (CFT) with the support of the care coordinator and family support partner. Participants are active members of the CFT who will, depending on age and/or cognitive development, assist in the selection of providers based on the POC and the expertise of the team members.

There will be an ongoing enrollment of providers into waiver services to ensure the capacity is available. The database will be updated and made available within the first month of waiver services. Additionally, the existing care management entities have their own provider databases that will ultimately be shared and merged with the MHA/MAPS-MD database.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i) through the terms of the Memorandum of Agreement between OHS and MHA. The DHMH PRTF waiver coordinator will conduct annual reviews of a sample of waiver plans of care to assure compliance with the waiver proposal and Medicaid regulations.

The sample will be statistically significant. MHA and Project Director will do a random selection of individual POC for review, sampling at least 10% of the POC each quarter.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- (•) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

  Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each*

that applies):

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Wraparound is a team-level decision making process. The team determines the various supports and services that need to be in place for the family with the family and youth driving the process. The team is responsible to hold each other accountable in ensuring the implementation of high quality services for the family. In addition, supervisors review the care of families with care coordinators on a weekly basis, Innovations Institute provides training and coaching to care management entities, which includes review of POCs and team observations, and there is oversight by the Local Management Board.

Families have access to any and all services made available in the Waiver Plan that will address their individualized needs. Families have the primary decision making responsibility around provider selection. If a family is dissatisfied with a provider, there is an internal process within care management organizations to address these needs and mediate as well as transition to another provider when needed. This includes dissatisfaction with care coordinators or family support partners.

The POC process is designed to identify and address the individualized needs of each family. If a plan is not working for the family, the plan is revisited and redesigned to better meet the needs of the family. The team shares the philosophy that "the family doesn't fail, the plan fails" and in turn needs to be redeveloped. Families' needs will be identified through CANS as mentioned in the prior questions.
MHA and Project Director will review charts for these areas on at least a quarterly basis, and the Evaluation Team will be brought together to review problems. This process is explored in more detail in the quality assurance process.

(a) The case manager is responsible for monitoring the implementation of plans of care by service providers. This is done as a part of the Child/Youth Family Team meetings that occur monthly. Since MHA is administering the waiver, MHA will sample plans of care, review participant records, and track and trend the results of quality management activities. Quarterly and annual reports that document the results of monitoring activities will be provided to the Medicaid Agency.

(b) The Medicaid Agency will review the quarterly and annual reports that are prepared by MHA. To address any service deficiencies, the Medicaid Agency will work in collaboration with MHA and the child/youth family team to implement any necessary changes to a participant's plan of care, prepare letters to waiver providers that document deficiencies, and impose provider sanctions as needed.

(c) MHA will document the results of ongoing monitoring activities in quarterly and annual reports that are provided to the Medicaid Agency.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and**

participant health and welfare may not provide other direct waiver services to the participant.

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

  The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DHMH provides broad Fair Hearing Rights to individuals who are denied choice of HCBS waiver services as an alternative to institutional care, denied services or providers of their choice, and whose services are suspended, reduced, or terminated. Specifically, COMAR 10.01.04 which governs Fair Hearings stipulates that the opportunity for Fair Hearing will be granted to individuals who aggrieved by any Department or delegate agency policy, action or inaction which adversely affects the receipt, quality or conditions of medical assistance. Each waiver participant receives a copy of the notice of fair hearing in the initial wavier application upon enrollment.

The waiver participant is notified in writing that services will be continued during the appeal process if the appeal is filed timely.

Process for Giving Notice to Applicants/Participants: If an applicant or enrolled participant is denied waiver eligibility – medical, technical or financial criteria – he/she and any representative that has been identified by the individual are sent a letter that contains the reason for the denial and a Fair Hearings notice. The Medicaid waiver eligibility unit sends all eligibility denial letters. Denial letters are copied to the case manager who will maintain this documentation as part of the participant's waiver record. The waiver eligibility unit also maintains a copy.

When a participant is aggrieved by a decision regarding his services or providers, MHA is responsible for providing the participant and representative with a notice identifying the action or inaction that the participant believes is impacting him/her adversely. This written notice contains the Medicaid Fair Hearing rights and the process for filing an appeal. This notice is maintained by the case manager in the participant's waiver record.

At the point of a decision, the participant will be provided with a written statement regarding their right to request a fair hearing. This statement will inform the participant of how to contact the Office of Administrative Hearings, and will also inform the participant that services will continue while the appeal is under consideration. The notice of adverse actions and the opportunity to request a Fair Hearing will be retained in the file of the participant for at least three years.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

MAPS-MD operates a hot line to handle customer consumer complaints and resolve issues.

In order to provide a procedure to hear, investigate, and resolve grievances regarding denial of services, MAPS-MD has staff including a psychiatrist, who is privileged to evaluate the type of service under review and the Medical Director. A waiver-eligible individual may file a grievance within 10 business days of service denial notification (orally, in writing or electronically), may have assistance at each level of the procedure and present supporting information and ask questions about the basis for the denial, and may appeal to the Office of Administrative Hearings.

MAPS-MD informs the applicant/participant in writing that he/she may request a reconsideration and maintain the right to a Fair Hearing or elect to request a Fair Hearing without the interim process of reconsideration. The letter contains the Program's standard notice with regard to Fair Hearing rights.
The grievance procedure and appeal rights regarding denial of services is outlined in COMAR 10.09.70.08. There are three levels of grievance: Level I is the grievance of the initial finding that medical necessity criteria have not been met. Review is conducted by the Utilization Review psychiatrist at MAPS-MD. Level II is the grievance of the Level I finding and is conducted by the Medical Director of MAPS-MD. Level III is the grievance of the Level II

finding and is conducted by the Core Service Agency of the individual's jurisdiction. At each level time frames are specified for notification of grievance receipt, determination of the findings, and the individual's rights to the full grievance process. The final level of appeal is to the Office of Administrative Hearings.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

MHA is responsible for the operation of the grievance/complaint system. MAPS-MD operates a hotline to handle consumer complaints and resolve issues.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The grievance/complaint system ensures the identification of and the appropriate and timely resolution of administrative service and quality of care complaints related to waiver participants. A complaint is defined as any communication, oral or written from a participant, participant's representative, provider, or other interested party to any employee of MHA expressing dissatisfaction with any aspect of MHA or provider's operations, activities, or behavior, regardless of whether any remedial action is requested. Administrative, service related and quality of care complaints are reviewed. Complaints/ grievances include, but are not limited to: concerns about perceived practitioners or provider's qualifications or competence, adverse experiences, poor outcomes, inadequate care or perceived harm, provider negligence with regards to policy and procedures, medical record documentation, reductions, denials or terminations of services, and confidentiality issues as well as accessibility and/or availability, which impact care.
Waiver participants are provided with a written summary of the complaint process and how to file a complaint during the initial Child/Youth Family Team meeting. MHA assists the participant as needed in completing forms. MHA will track all grievances/complaints.
The process used for resolving grievances/complaints begins with the MHA representative documenting the pertinent information and the nature of the complaint on the grievance/complaints Action Report. The MHA representative addresses the issue according to the time frames outlined below. The MHA representative completes the initial investigation, and then in conjunction with the participant, family and other related parties, performs all other necessary follow up, summarizes the finding, and determines and implements the appropriate action steps. This information will be documented on the grievance/complaints action report and submitted to the Office of Health Services Division of Waiver Programs within 30 days.
Timeframes for resolving complaints are as follows: 24 hours: emergency medically related complaints, 5 days: non-emergency medically related complaints and 30 days: administrative service delivery complaints.
Participants or their representatives will be notified of the disposition of the complaint and right to appeal as appropriate. Results will also be reported to the participant/representative and provider as appropriate.
If the participant indicates that he/she is not satisfied with the response, the agency must respond in writing within 30 calendar days from the date of the agency's initial response.
Individuals will be informed by the waiver case manager at the initial plan of care meeting that they may file an appeal for a Fair Hearing directly to the Office of Administrative Hearings. Filing a complaint or grievance is not a pre-requisite for requesting a Fair Hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All providers will be required to follow the current Policy on Reportable Incidents set forth by the MHA. The purpose of the policy is to protect the rights of individuals served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well being of individuals receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as time frames for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of abuse, neglect, death, hospital visits, injury, theft, medication errors, leave without notification, incidents requiring law enforcement or fire department as well as other incidents. Providers are required to follow this policy and to notify MHA of an incident within 24 hours by sending a copy of the report. The policy clearly informs providers of the requirement to report all allegations of abuse or neglect to MHA, the State's Protection and Advocacy System, and local law enforcement. MHA contacts the provider for a verbal report of the incident. A review of all incidents will be included in the trending/ tracking report as a part of the quality management plan. Additionally, the policy requires providers to submit a report within 21 days to MHA regarding the outcome and follow-up of the incident.
Waiver participants and families are given the MHA waiver program contact number upon enrollment into the program to report incidents to MHA. Providers document the incidents on a Reportable Incident form and follow-up with the provider or other party involved accordingly. Waiver participants are strongly encouraged to keep the contact information posted in their bedroom or in a location of their choosing that is easily accessible.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

MHA or its designee will conduct trainings on policies and procedures around reportable events. Reportable event information is posted on DHMH's website. The care coordinator provides the participant information regarding contact information for concerns or complaints, and information on reportable events, including suspected or actual abuse, neglect, or exploitation. The contact information includes care coordinator and customer service, and MHA's Waiver Project Coordinator's name and phone number.

Training on policies and procedures for incident reporting will be required for all new providers within the first 90 days of service. After that point, training will be provided on an annual basis.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Providers are required to report any critical events or incidents to MHA within 24 hours by sending a copy of the report. MHA uses a critical incident action report form which includes a summary of the findings, action taken by the provider or MHA and recommendations to improve the quality of care for waiver participants. MHA verbally notifies the Office of Health Services (OHS) within 48 hours of receipt of an incident report. In addition, a review of all incidents will be included in the trending/ tracking report as a part of the quality management plan. Additionally, waiver providers are required to submit a report within 21 days to MHA regarding the outcome and follow-up of the incident.

MHA reviews all reportable incidents and written 21-day reports, provides any needed follow-up, files the reports, and then tracks the trends of these incidents on a quarterly basis. The trend reports are sent to OHS each quarter where they are reviewed. The Department may make changes to the program based on information received from reports if appropriate.

If allowable under Maryland law, the investigation results will be shared with the participant and other relevant parties after MHA has received the report, which is required within 21 days after the incident. Examples of instances where the results would not be shared would include child abuse and neglect investigations, where the reporter of such an allegation is only entitled to be informed of the fact that an investigation was launched, not of the outcome of such investigation . However, every effort will be made to keep participants and relevant parties informed of the outcomes. Participants will be informed of all outcomes that directly affect their health or well-

being. Parents/family members are notified immediately upon receiving reports of any such critical events or incidents involving their children or youth.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The responsibility of reporting and response to critical incidents is shared by the Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ) and MHA. Providers are required to send copies of any critical incidents to both entities. Once MHA gets a report, MHA staff conduct an investigation.

MHA and OHCQ conduct annual site visits of waiver providers to ensure their compliance with the critical incident reporting system among other regulations. The OHCQ conducts investigations as necessary pertaining to a critical incident and the reports are shared with MHA and OHS. The care manager also meets at least monthly with the Child/Youth Family Team, these meetings serve as additional oversight. Lastly, the OHS reviews the quarterly incident report trends submitted by MHA as yet another checkpoint in the process.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State follows CMS regulations related to the use of restraints or seclusion for hospitals. These regulations apply to hospitals and RTCs. A hospital or PRTF will not be providing waiver services. By state law only a physician can order S&R and, as noted above, no waiver service provider should be using S&R. The use of seclusion or restraint is not a reportable critical incident. Complaints about seclusion or restraint can be reported by anyone to OHCQ. MHA will monitor reports to OHCQ for waiver providers.
OHCQ is the licensing arm of the Department of Health and Mental Hygiene (DHMH). OHCQ, MHA and Medicaid are all administrations under DHMH.

No Waiver Service Provider will be using Seclusion and Restraint. Due to this clarification Section G – 2 is not relevant.

State law does not prohibit the use of any type of restraint but follows CMS regulation and JCAHO standards.

Maryland follows CMS regulations. Maryland has a CMHS seclusion and restraint grant to decrease use of seclusion and restraint in its facilities. A training manual to prevent use of S&R is being used in MHA public hospital units and RTCs for children, youth, and adolescents. The training focuses on techniques to avoid use of restraint.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and

how such oversight is conducted and its frequency:

No Waiver Provider of Service will use seclusion and restraint. The Office of Health Care Quality at DHMH provides oversight of seclusion and restraint in other settings.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  MHA monitors complaints on an ongoing basis.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
  Complete Items G-2-b-i and G-2-b-ii.

  i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Participants usually reside with their families who are responsible for their medications. In the circumstances that a child or youth is in foster care or a group home, the foster parent or group home provider is responsible

for monitoring the child's or youth's medications.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Medicaid Pharmacy Program has a coordinated PRODUR system to identify contraindicated medications at the point-of-sale whose drugs are being paid for by Medicaid. The MHA is responsible for oversight of all children and youth. CME care managers will review the use of medication as part of their oversight of the POC on a monthly basis. Additionally, within the CME, Care Management Supervisors will review the use of medication as part of their oversight of the POC on a quarterly basis Secondary review of selected POC by Project Director and MHA will also focus on medication use.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. **Provider Administration of Medications.** *Select one:*

- (●) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
  Do not complete the rest of this section

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. **Medication Error Reporting.** *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- ( ) **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to

undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Appendix H: Quality Management Strategy (2 of 2)

Attachment #1

The Quality Management Strategy for the waiver is:
The quality management strategy addresses the six home and community-based waiver assurances. The plan identifies the State and local agencies and their roles and responsibilities in providing oversight, interventions, ongoing monitoring and quality assurance activities related to each waiver assurance. The plan is designed to generate information and data that can be used to monitor and improve the way the waiver operates.

Specific monitoring strategies are identified for each assurance and assigned to specific entities. These monitoring strategies are intended to track compliance with waiver regulations and to help identify areas within the program that may need to be changed, or modified to improve the quality of services offered to participants.

The monitoring strategies for each assurance are summarized below.

Level of Care (LOC)
--MHA monitors the timeliness of the initial LOC determinations and re-determinations through a tracking system developed by MHA.
--MHA and OHS discuss level of care issues and seek resolution as appropriate.

The LOC will be reviewed every six months as part of the re-evaluation process and the Local Coordinating Council, the LMB, and the CSA will be responsible for ensuring that the LOC are accurate and appropriate. When the LOC is not correct, the CASII will be re-administered with the input of the entire CFT, including the participant, and the CSA and LMB. If the LMB, CSA, LCC, MHA, or project director determine this to be a systemic issue, additional training will be provided on the administration of the CASII. Additionally, if there are any care coordinators or supervisors found to frequently have inaccurate LOC for children or youth on their case load, additional supervision will be provided by the CME.

Plan of Care (POC)
--The case manager monitors the effectiveness of the POC on a quarterly basis during face-to-face contact with the participant.
--MHA project coordinator reviews a sample of the POCs quarterly to monitor whether the appropriate documentation is in the record: POC, signed Rights & Responsibilities form, consent for Waiver Services, Participant Experience Survey, and quarterly site visit reports.
--The OHS PRTF Waiver Coordinator conducts an annual record review of a sample of waiver participant records.
--The Wraparound Fidelity Index is conducted every 4 to 6 months to monitor the quality and implementation of the POC and related outcomes.

A 10% sample will be reviewed by the project manager, taking a random sample of plans. A statistically significant sample will be reviewed by OHS. Following the review, there will be a debriefing with CME, LCC (including LMB and CSA), OHS, MHA, and members of the evaluation team to review findings and discuss whether children or youth are receiving appropriate services in a timely fashion in accordance with their needs and strengths.

Qualified Providers
--MHA and OHS are responsible for assuring that qualified providers are enrolled in the network to serve the needs of waiver participants.
--MHA/MAPS MD oversee network and the provider credentialing process.
--DHMH OHCQ licenses PRTFs and investigates allegations of abuse and incidents that threaten the health and safety of individuals.

--DHMH OHCQ conducts annual site visits for providers licensed under COMAR 10.22.07 and 10.22.08.
--MHA reviews OHCQ licensure reports and monitors complaints and incidents. MHA follows up with the provider, CME, and OHCQ when life threatening events occur.

In sampling case records, the project director and MHA would review the CME's files on service providers to ensure adherence, including criminal background checks and training requirements. It is also the responsibility of the local management boards in monitoring the CME, and the responsibility of the CME in monitoring its service providers. The CME receives regular reports from service providers regarding services provided and adherence to requirements. Additional oversight is provided by the CSA, allowing for three to four levels of oversight and monitoring. Finally, oversight will occur at the individual level through feedback from the CFT in their discussion of service receipt and satisfaction with services and providers.

Health and Welfare
--A reportable event policy will ensure the health and safety of waiver participants.
--MHA uses an Outcomes Measurement System for all clients who receive community services as a part of the initial and reassessment for care process. All PRTF waiver participants and/or parents (depending on the age of the participant) will complete this questionnaire at enrollment and at six month intervals for the duration of their enrollment in the waiver.
--MHA staff review and follow-up on all reportable events.
--MHA reports quarterly to DHMH on all reportable events (complaints and incidents).
--MHA responds to any deficiencies identified.

Maryland will track and trend reportable incidents using a results accountability process. Tracking and reporting will occur in the following categories: how much did we do, how well did we do it, and is anyone better off?

How much did we do:
• Number of critical incident reports filed, by jurisdiction and type of report
• Number of trainings provided on critical incident reporting and prevention of critical incidents
How well did we do it:
• % of critical incident reports filed with MHA within 24 hours
• % of critical incident reports filed with OHS by MHA within 48 hours of receipt of report
• % of waiver service providers submitting a report to MHA within 21 days of the outcome and follow-up of the incident
Is anyone better off?
• Reduction in number of critical incident reports from one quarter to the next

Discovery: Provision of incident reports and outcome reports to MHA
Remediation: Meetings and written reports between MHA, Project Director, CME, Service Provider, and CFT to address any outstanding issues and to ensure that the safety and well-being of participants is adhered to at all times
Process Improvement: Ongoing technical assistance on prevention of critical incidents, enforcement of criminal background checks, training requirements, and other standards and qualifications of providers.

Administrative Authority
--DHMH Medicaid is the single state Medicaid agency responsible for the implementation and oversight of the Waiver for PRTF Waiver. MHA is the operating state agency responsible for the day-to-day operations of the waiver and oversight of the CMEs. MHA and OHS are agencies in DHMH. Each agency's directors report to the Secretary of DHMH.
--OHS and MHA are developing a Memorandum of Agreement which outlines each entities roles and responsibilities.

--OHS and MHA are implementing a Quality Management Plan that outlines in detail quality assurance activities and responsible entities.
--OHS and MHA will hold regular interagency waiver coordination meetings to discuss current issues and policy and to problem solve.
--OHS will require MHA to send quarterly reports on reportable events that includes trending and tracking of data and plans for remediation.
--MHA is refining its tracking and trending system that is used to produce quarterly reports that identify problems

related to program design and changes that MHA has made to the system as a result of analyzing data.
--MHA will monitor CMEs to facilitate discovery of problems related to access to services and/or provision of services. MHA and OHS evaluate the need for changes in the program after receipt of these findings.

Financial Accountability
--MHA's ASO (MAPS-MD) will reimburse providers.
--The MHA / MAPS-MD billing system is integrated with MMIS so that MAPS-MD can submit requests for federal financial participation.
--MHA fiscal staff conduct a quarterly budget and performance review of MAPS-MD.
--MHA and DHMH identify inappropriate payments and overpayments for recovery by DHMH.
--MHA will look at encounter data to ensure the provision of care is consistent with services authorized on the POC.

Financial reviews of claims are conducted quarterly and a single state audit is conducted on an annual basis. State legislative audits are conducted for medical care programs about once every 3 years, while departmental close-outs audits are conducted once a year.
Remediation and Improvement
--OHS and MHA have three primary forums for reviewing findings from the discovery process, establishing priorities and developing strategies for remediation and improvement. These are the: Waiver Quality Council (WQC), Maryland PRTF Advisory Committee, and Monthly interagency waiver coordination meetings

Waiver Quality Council (WQC)
The interagency WQC meets on a regular basis to review findings from a variety of sources, such as Reportable Event data and operating state agencies waiver operation experiences. The primary source of findings is the quarterly Reportable Event data sent in by the operating State agencies. This data is aggregated and analyzed by DHMH and the operating state agencies. Issues are tracked and trended for presentation to the WQC. It is the then the function of the WQC to develop strategies for remediation and improvement of identified issues. The WQC then identifies which issues to address. Development of the strategies is either addressed by the Council at large or assigned to smaller work groups.

Advisory Committee
The Maryland PRTF Advisory Committee brings together advocates for youth and their families, providers, stakeholders, advocates, and staff from public agencies. Quality management issues are shared with the Advisory Committee so that there will be an opportunity for OHS and MHA to benefit from a broader perspective due to the Committee composition. The Committee may also bring issues and concerns to the table that are different from those that come to the attention of the WQC, such as provider concerns. Some concerns will end up being referred to the WQC due to their complexity and need for further study. For some issues, however, the Committee will be best positioned to propose suggestions for program improvements.

Interagency Waiver Coordination Meetings
OHS and MHA waiver administrative staff meet monthly to discuss policy, initiatives and problem areas of the waiver. Often there are administrative issues with the operation of the waiver that can be best addressed at this level. For example, at times it may become clear that providers are not aware of certain practices they should be following to render services appropriately. The staff participating in the interagency meetings may develop a strategy to provide written information to providers on this problem area. The group will assess the strategy at future meetings to determine if improvements have been made or further work needs to be done. As appropriate, some issues will be raised to the level of the WQC by the Waiver Coordination group.

Communication and Reporting
The methods used to compile quality data are described above with regard to the Reportable Event process. Additionally, ad hoc reports are generated to produce data that is needed to inform critical decisions on quality management. Statistical and informational reports will be developed by MHA and OHS to answer questions or provide explanations to members of the PRTF Advisory Committee with regard to quality management in the waiver. OHS and MHA will communicate quality management information to providers and case managers through trainings, conferences, informational mailings and formal transmittals. Participants and families are kept informed during scheduled POC meetings. The primary method of communicating about quality management in the waiver to the general public is through the websites maintained by MHA and OHS.

Evaluation and Revision
The Quality Management Plan used in the PRTF waiver provides a strong, basic framework for quality management. OHS and MHA view the QMP as a fluid document subject to building upon or modifying at any point a change is indicated. OHS and MHA formally review the QMP on an annual basis. The forum for the review is the

interagency waiver coordination meetings between the two agencies. At a minimum there will be an annual comprehensive review, with quarterly review of case sampling and ad hoc review as needed.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Single State Audit
There is an annual independent audit of Maryland's Medical Assistance Program that includes Medicaid home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by Maryland's Comptroller's Office. The present contractor is Abrams, Foster, Nole, and Williams.

Department of Legislative Services
The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid and the Mental Hygiene Administration are audited on a two-year cycle.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates were based on current rates for some services, as well as from comparisons of rates for similar services in other states. An additional cost was then added due to the high end, complex clinical needs of the youth who will be served. Waiver services are based on current rates for Maryland Wraparound services, which were initially based on rates used for the DAWN Project in Indiana.

Rates will be made available on a fee schedule.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Individual providers will bill MHA for services that are rendered. MAPS-MD will pay providers through MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

No. Public agencies do not certify expenditures for waiver services.

Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid

***Select at least one*:**

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

Certified Public Expenditures (CPE) of Non-State Public Agencies.

Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

MHA or its designee will review a sample of care plans to validate that services in the plan of care were rendered. MHA will pay providers through MMIS. Edits in the system will ensure that individuals are Medicaid eligible and enrolled in the waiver.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with

efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

- **No. Public providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. Public providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to Public Providers.

Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to public providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services.**

Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements**

under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly

expended by public agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- **Not Applicable**. There are no non-State level sources of funds for the non-federal share.
- **Applicable**

Check each that applies:

- **Appropriation of Local Revenues.**

  Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source (s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

- **Other non-State Level Source(s) of Funds.**

  Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one*:

- **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- **The following source(s) are used**

Check each that applies:

- **Provider taxes or fees**
- **Provider donations**
- **Federal funds (other than FFP)**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Since room and board payments are made by other agencies, they are separate from the Medicaid payments in this waiver. No waiver services cover room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - **i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care:

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	32474.61	52582.50	85057.11	82880.14	4120.37	87000.51	1943.40
2	45465.06	73800.00	119265.06	116323.00	5783.00	122106.00	2840.94
3	47739.89	77490.00	125229.89	122139.00	6072.00	128211.00	2981.11
4	50125.55	81364.00	131489.55	128245.00	6375.00	134620.00	3130.45
5	52631.96	85432.00	138063.96	134657.00	6693.00	141350.00	3286.04

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		PRTF	
Year 1	87	87	

Year 2	87	87	
Year 3	124	124	
Year 4 (renewal only)	124	124	
Year 5 (renewal only)	448	448	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

For each waiver year, the total "days enrolled" was divided by the number of unduplicated participants, (e.g., there are a total 27,000 enrollment days for 87 waiver participants during the first year of the waiver, which results in an ALOS of 310 days). Enrollment days for each month are estimated by multiplying the number of unduplicated participants by the number of enrollment days in a month (30 days). Monthly enrollment days are summed to determine the annual number of "days enrolled".

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D estimates the costs of waiver services each year by summing the cost of each of the waiver services. The cost of each of the waiver services was calculated by multiplying the reimbursement rate by the estimated average units of the waiver service used by each participant. Annual inflation of 5% was applied.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' estimates the cost of all State Plan services for a waiver participant, including PRTF utilization. This was calculated by summing 1) the average HealthChoice capitation costs (for Medicaid State Plan physical health services) for a similarly aged population enrolled in HealthChoice, 2) average historic specialty mental health service utilization over time for a cohort that was RTC level of care, and 3) mental health drug costs for a similar population. It was assumed that the availability of waiver services would reduce PRTF and other specialty mental health service costs by 15%. Annual inflation of 5% was applied.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

This estimate reflects the cost of an average PRTF cost without the waiver, under the current fee-for-service model, based on average PRTF length of stay and average per diem cost of a PRTF for the most recent year of complete data. Annual inflation of 5% was applied.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

This estimate reflects the cost of all State Plan services without the waiver. This summed 1) the average

HealthChoice capitation costs (for Medicaid State Plan physical health services)for a similarly aged population enrolled in HealthChoice, 2) the cost of mental health drugs for the period during the year when the individual is not in the PRTF, and 3) the cost of specialty mental health services experienced by individuals post PRTF discharge (pro-rated for the number of days in a year beyond the PRFT average length of stay).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
In-Home Respite
Family and Youth Training
Residential Respite
Mobile Stabilization Support Service
Supported Employment
Peer-To-Peer Support
Caregiver Peer-To-Peer Support
Experiential and Expressive Therapies

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Respite Total:						**469800.00**
In-Home Respite	day	87	36.00	150.00	**469800.00**	
Family and Youth Training Total:						**422820.00**
Family and Youth Training	hour	87	108.00	45.00	**422820.00**	
Residential Respite Total:						**469800.00**
Residential Respite	day	87	36.00	150.00	**469800.00**	
Mobile Stabilization Support Service Total:						**536355.00**
Mobile Stabilization Support Service	hour	87	90.00	68.50	**536355.00**	

Supported Employment Total:						**143516.07**
Supported Employment	month	87	2.25	733.16	**143516.07**	
Peer-To-Peer Support Total:						**203580.00**
Peer-To-Peer Support	day	87	78.00	30.00	**203580.00**	
Caregiver Peer-To-Peer Support Total:						**203580.00**
Caregiver Peer-To-Peer Support	day	87	78.00	30.00	**203580.00**	
Experiential and Expressive Therapies Total:						**375840.00**
Experiential and Expressive Therapies	hour	87	72.00	60.00	**375840.00**	

GRAND TOTAL:	**2825291.07**
Total Estimated Unduplicated Participants:	**87**
Factor D (Divide total by number of participants):	**32474.61**
Average Length of Stay on the Waiver:	233

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Respite Total:						**657720.00**
In-Home Respite	day	87	48.00	157.50	**657720.00**	
Family and Youth Training Total:						**591948.00**
Family and Youth Training	hour	87	144.00	47.25	**591948.00**	
Residential Respite Total:						**657720.00**
Residential Respite	day	87	48.00	157.50	**657720.00**	
Mobile Stabilization Support Service Total:						**750949.20**
Mobile Stabilization Support Service	hour	87	120.00	71.93	**750949.20**	
Supported Employment Total:						**200923.02**
Supported Employment	month	87	3.00	769.82	**200923.02**	

Peer-To-Peer Support Total:						**285012.00**
Peer-To-Peer Support	day	87	104.00	31.50	**285012.00**	
Caregiver Peer-To-Peer Support Total:						**285012.00**
Caregiver Peer-To-Peer Support	day	87	104.00	31.50	**285012.00**	
Experiential and Expressive Therapies Total:						**526176.00**
Experiential and Expressive Therapies	hour	87	96.00	63.00	**526176.00**	

GRAND TOTAL:	**3955460.22**
Total Estimated Unduplicated Participants:	**87**
Factor D (Divide total by number of participants):	**45465.06**
Average Length of Stay on the Waiver:	310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Respite Total:						**984341.76**
In-Home Respite	day	124	48.00	165.38	**984341.76**	
Family and Youth Training Total:						**885836.16**
Family and Youth Training	hour	124	144.00	49.61	**885836.16**	
Residential Respite Total:						**984341.76**
Residential Respite	day	124	48.00	165.38	**984341.76**	
Mobile Stabilization Support Service Total:						**1123886.40**
Mobile Stabilization Support Service	hour	124	120.00	75.53	**1123886.40**	
Supported Employment Total:						**300691.32**
Supported Employment	month	124	3.00	808.31	**300691.32**	
Peer-To-Peer Support Total:						**426599.68**
Peer-To-Peer Support	day	124	104.00	33.08	**426599.68**	

Caregiver Peer-To-Peer Support Total:						**426599.68**
Caregiver Peer-To-Peer Support	day	124	104.00	33.08	**426599.68**	
Experiential and Expressive Therapies Total:						**787449.60**
Experiential and Expressive Therapies	hour	124	96.00	66.15	**787449.60**	

GRAND TOTAL:	**5919746.36**
Total Estimated Unduplicated Participants:	**124**
Factor D (Divide total by number of participants):	**47739.89**
Average Length of Stay on the Waiver:	360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Respite Total:						**1033564.80**
In-Home Respite	day	124	48.00	173.65	**1033564.80**	
Family and Youth Training Total:						**930119.04**
Family and Youth Training	hour	124	144.00	52.09	**930119.04**	
Residential Respite Total:						**1033564.80**
Residential Respite	day	124	48.00	173.65	**1033564.80**	
Mobile Stabilization Support Service Total:						**1179984.00**
Mobile Stabilization Support Service	hour	124	120.00	79.30	**1179984.00**	
Supported Employment Total:						**315727.56**
Supported Employment	month	124	3.00	848.73	**315727.56**	
Peer-To-Peer Support Total:						**447878.08**
Peer-To-Peer Support	day	124	104.00	34.73	**447878.08**	
Caregiver Peer-To-Peer Support Total:						**447878.08**
Caregiver Peer-To-Peer Support	day	124	104.00	34.73	**447878.08**	

Experiential and Expressive Therapies Total:						**826851.84**
Experiential and Expressive Therapies	hour	124	96.00	69.46	**826851.84**	

GRAND TOTAL:	**6215568.20**
Total Estimated Unduplicated Participants:	**124**
Factor D (Divide total by number of participants):	**50125.55**
Average Length of Stay on the Waiver:	360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Respite Total:						**3920824.32**
In-Home Respite	day	448	48.00	182.33	**3920824.32**	
Family and Youth Training Total:						**3528161.28**
Family and Youth Training	hour	448	144.00	54.69	**3528161.28**	
Residential Respite Total:						**3920824.32**
Residential Respite	day	448	48.00	182.33	**3920824.32**	
Mobile Stabilization Support Service Total:						**4476595.20**
Mobile Stabilization Support Service	hour	448	120.00	83.27	**4476595.20**	
Supported Employment Total:						**1197719.04**
Supported Employment	month	448	3.00	891.16	**1197719.04**	
Peer-To-Peer Support Total:						**1699210.24**
Peer-To-Peer Support	day	448	104.00	36.47	**1699210.24**	
Caregiver Peer-To-Peer Support Total:						**1699210.24**
Caregiver Peer-To-Peer Support	day	448	104.00	36.47	**1699210.24**	
Experiential and Expressive Therapies Total:						**3136573.44**
Experiential and Expressive Therapies	hour	448	96.00	72.93	**3136573.44**	

GRAND TOTAL:	**23579118.08**
Total Estimated Unduplicated Participants:	**448**
Factor D (Divide total by number of participants):	**52631.96**
Average Length of Stay on the Waiver:	360